



CUSTOM Rx MANAGEMENT

Prior Authorization Request

Submit this completed form via:

Fax: **800-480-4840**, Attention: Authorizations

OR

Mail: Serve You, Attention: Authorizations

10201 W. Innovation Drive, Suite 600

Milwaukee, WI 53226

OR

Email: **priorauthorizations@serve-you-rx.com**

For questions, please call **800-759-3203**

SECTION I – GENERAL INFORMATION

Patient Information

Patient Name:

Member ID:

Address:

City, State, ZIP:

Date of Birth:

Prescriber Information

Prescriber Name:

NPI:

Specialty:

Address:

City, State, ZIP:

Telephone Number:

Fax Number:

SECTION II – REQUESTED MEDICATION

Name:

Strength:

Frequency:

Expected duration of therapy:

If this is a continuation of therapy, provide start date:

SECTION III – CLINICAL INFORMATION

Diagnosis:

Diagnosis code (ICD):

Date of diagnosis:

List all medications the patient has previously tried and failed for treatment of this diagnosis including reason(s) for discontinuation and provide all relevant clinical documentation that supports use of this medication. If a continuation of therapy, provide documentation of clinical improvement or significant clinical response.

☐ **Urgent Review Requested**

Prescriber Signature: _____

Date: _____

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.

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